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The developments in child psychiatry in the past 25 years have been encouraging but represent only a prelude to the significant work that must be done relatively soon to meet the needs of the contemporary child. Before 1940, the desirability of multidisciplinary study of the child had been well established, and child guidance clinics had appeared. Until the 1960's, however, the focus was on the clinical study of individual patients and families, rather than population studies, and generalizations were made from the former to the latter. Concern for the poor and the black was dormant for too long in the past quarter century; it is in such areas as poverty and racism that serious psychological and organic problems in children occur. Specifically, research in child development must be concerned with many important factors, including (1) the "test bias" in interpreting results of achievement tests; (2) the prenatal and paranatal factors that influence brain development; (3) nutritional factors, before and after birth; (4) the psychosocial environment of the child, especially the family environment; (5) the influence and role of school; and (6) the effects of racism. (WD)

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CHILD PSYCHIATRY: THE PAST QUARTER CENTURY

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At the risk, in this election year, of sounding like a candidate for office, I cannot forego public acknowledgement of my pleasure at being invited back to Montreal. Each of my visits here has been unusually rewarding, both because of the beauty of this city and the stimulation provided by its intellectual environment. This occasion is a particularly welcome one, acknowledging as it does the 25th anniversary of an outstanding department of psychiatry and its distinguished chairman. For a citizen of the United States, Montreal has especial meaning with the tension between its two cultures and the struggle of a formerly oppressed language group for its proper place in the sun. A constructive outcome will provide a model of great significance to our own communities, wracked as they are by internecine conflict. For these several reasons, then, I am grateful to Professor Cleghorn for the opportunity to be here.

He has asked me to comment upon "developments in child psychiatry in the past quarter century" and "to map out promises of research in the years ahead." Neither task is an easy one. Historiography is a constant dialogue between past and present; it takes new form from the grounds of the shifting present. The historian twenty-five years hence will almost certainly view our recent past from perspectives quite different from our own, having at his command new viewpoints and more distance from the controversies in which we are still engaged. We can only hope he will be kind to thosef us then still alive, and due respect for our venerability if not for our perspicacity. I beg him to forgive me for limiting my survey mostly to this continent, but this is the only scene I know well enough to dare these comments.

Fortunately, our assessment of recent developments can take as its starting point the insightful and balanced comments of Professor Kanner,

who, in a series of scholarly and delightfully literate publications,(1-3), has attended the birth and early childhood of child psychiatry. The paternity of this hybrid invites us to invoke the mechanism of superfecundation, involving as it did general psychiatry, the juvenile court movement, defectology, education, child development, psychoanalysis, pediatrics and child guidance. Although textbooks concerned with the "mental diseases" and "insanity" of children had appeared before the turn of the century, they were primarily exercises in the imposition of adult nosology upon childhood disorders(2). It was not until 1926 that Homburger (4) wrote the first treatise on the psychopathology of childhood that can be said to be informed by a concern for the child as a person and it was not until 1935 that Kanner (5) published the first American textbook with the title "Child Psychiatry".

By the 1930's, child guidance clinics were a burgeoning feature of the North American scene. Tramer's Zeitschrift für Kinderpsychiatrie had been founded, and Heuyer had organized an international congress in Paris under the title "Psychiatrie infantile". The year that marks the opening of our survey (1943), appropriately enough, was the year in which Professor Kanner reported the previously undescribed syndrome that has come to be known as early infantile autism (6), the first instance of a psychotic disorder peculiar to childhood.

To that point in time, the contributions of child psychiatry might be summarized in these terms. The desirability of multidisciplinary study of the child in his family had been well established. At an operational level, this was reflected in the collaboration of the social worker, the psychologist and the psychiatrist in the child guidance clinic and in the

eligibility of all three groups for membership in the American Orthopsychiatric Association (7). The first effective drugs, the amphetamines, had been introduced (8). The thesis that adult disorders have antecedents in childhood experience had been broadly accepted; true, this idea had been introduced into psychiatry by Freud without the benefit of child study four decades earlier, but the accumulating clinical reports of child psychiatrists had given it - or at least appeared to have given it - empirical support.

The enthusiasm for prevention, again a doctrine enunciated at the turn of the century in the mental hygiene movement, had now become the province of children's clinics. In much the same spirit that Victor Hugo had proclaimed that the opening of each new school meant the closing of a prison, the community was led to expect that each new child clinic made obsolete an adult mental hospital. However distant the day of its realization might seem, given the shortages of funding and manpower then as now, there was no lack of conviction that the control of mental illness could be attained by a proper network of child guidance clinics, training of school teachers, and education of parents. And this conviction was no mere matter of naïve optimism on the part of our professional forebears; the nature of their daily clinical work with its high rates of symptomatic improvement in the children they cared for appeared to verify their beliefs.

Yet for all the honor due to child psychiatry for having pioneered a broader view of patient-family-community interaction than was then typical of adult psychiatry, our horizons were constricted by our focus on the clinical study of the individual patients and families who passed through our clinic doors. It is only in the last decade that we have begun to recognize that population studies are essential (9) and that clinic intake

has unintended as well as deliberate bias built into it (10). Once appropriate controls for social class are introduced, it becomes difficult to verify the widespread assumption that such variables as age and method of weaning, toilet training practices, sex education or the parental attitudes measured by standard inventories distinguish clinic patients from other children (11). Such factors do indeed vary significantly by social class but they fail to predict patienthood. In contrast to such factors, what did discriminate patients from controls, in a study of a sample of our clinic population, was the experience of separation from parents by illness, death or desertion and the occurrence of marital distress (11). Many of the formulations which seem to have explanatory value when applied in retrospect to patient populations skewed in unknown fashion by gate keeping procedures disappear into insignificance when appropriate sampling and control techniques are introduced. Such errors, in my estimation, have stemmed in part from the isolation of the child guidance clinic from medicine, on the one hand, and from child development on the other. No physiologist would describe a normal heart in terms derived solely from the study of a failing one; had he done so, Starling would have concluded that ventricular output decreases rather than increases in relation to ventricular dilatation. Yet we have generalized from our clinical work with troubled families to theories of normal development. Freud's experience before the turn of the century should have warned us of the unreliability of our patients' reconstructions of their past; what he first thought to be historical events he later discovered to be fantasy. Yet he and we have persevered in our preoccupation with those fantasies in lieu of the more laborious task of accumulating detailed prospective accounts of the vicissitudes of development. It was only in

the last decade that systematic longitudinal studies by such careful workers as Professor Chess and her collaborators have begun to supply the information necessary for a meaningful account of the interaction between temperamental characteristics, parental behaviors, and social experiences in generating personality traits (12).

It is therefore not surprising that the promisory note of prevention issued by the mental hygienists has not been able to be redeemed (13). If theories of cause rested on such uncertain foundations, nonspecific interventions are not likely to have been highly productive. Indeed our decisions on the "suitability" of particular children for treatment seemed to have been based more on our class biases than on the patients' psychiatric needs (14). The Furman et al. study of voluntary psychiatric facilities, supported by charitable as well as tax funds, identified preferential service to those health areas that were better off economically (15) The most recent survey, carried out by the New York Council on Child Psychiatry under the sponsorship of the Joint Commission on the Mental Health of Children, decried the long waiting periods for screening, prolonged intake procedures, clinic hours inappropriate for working parents, and other factors which summed to produce high drop-out rates and differential likelihoods for treatment such that the least ill and the least poor families (within clinic income ceilings) were those most likely to be treated psychotherapeutically (16).

On the other hand, the most significant long term follow-up study ever carried out in our specialty has documented the lamentable outcome of just those children least preferred by clinic intake policy, the antisocial, the aggressive, the disorganized (16). As Professor Robins and her co-workers have shown, the neurotic child, though still at higher risk for psychiatric illness in adulthood than classroom controls, has

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the best prognosis for favorable outcome even in the absence of care. Yet just such children are, or at least have been, preferrentially sought by therapists. Mind you, this is no injunction to sprinkle psychotherapy on delinquents; there is little evidence that they benefit therefrom (17). It is a call to concentrate our efforts on developing methods of care for those disorders that constitute the major threats to public health (18).

To its credit, the past decade has seen the first systematic studies of the outcome of psychotherapy for children. In general, the findings have not been reassuring (19). Although occasional studies, such as one my associates and I have carried out (20) do provide some evidence in favor of psychotherapy, most studies have been unable to provide systematic evidence of benefit when treated are contrasted with waiting list or designated controls.

This point requires clarification. Not to have found a difference is not equivalent to having demonstrated that there was <u>in fact</u> no difference. Measures of outcome employed in most studies are admittedly crude; significant differences in attitude and in values, which may stand a child and his parents in good stead for the future, may emerge from sensitive and skilled psychotherapy and not be reflected in symptom counts, given the evanescence of symptoms in children (21). But the counter-assertion that change <u>has</u> been produced requires documentation. It is yet to be forthcoming. What is remarkable is how little effect these studies with their Scots verdict of "not proven" have had on professional practice. Surely, at the least they should have lead to major investment of energy and effort in studies to define the indications for, the best methods of, and the limitations to psychotherapy rather than what can only be compared

to a religious conviction in the possession of an exclusive road to salvation. And for all the interest aroused by the newer forms of psychological treatment such as family therapy (22) and behavior therapy (23) there has been just the same dearth of controlled studies and the same evangelical proselytizing by the newly converted. Let me make it clear if I can: I regard both of these innovations as substantial contributions. I plead only for the necessity of controlled evaluation of their efficacy. I urge only that we abandon the Doctrine of Panacea and instead begin with the more likely proposition that particular methods will best suit particular patients and that the obligation of the psychiatrist is to be competent with a variety of treatment methods from which he can choose the one best suited for the individual patient.

All too often, what has been the liberation of one generation becomes the bondage of the next. If we can fairly claim credit for the introduction of the team of psychologist, social worker and psychiatrist, we are also guilty of having elevated it to what Kanner has termed "the holy trinity". Countless extra hours go into "interdisciplinary communication" in situations where one qualified professional could more effectively manage the problem without ending up talking to himself. More often, the "team" is used as a shibboleth when in fact there is not and cannot be a team simply by virtue of the relative distributions of time for the various disciplines at the clinic. There has been an ultimate blurring of roles as social workers have become junior psychiatrists - with no one doing the by now low prestige social work - as psychiatrists function exclusively as psychotherapists - with no one competent to do the neuropsychiatric evaluation - and psychologists can be distinguished from psychiatrists only by their

lower earnings and lower caste. Need I argue that it is well past time for us to re-examine the training for each discipline in relation to its actual professional function (24) and to utilize whatever special skills each might have in relation to the real problems of real people? Do we offer something tangible and useful to those who seek our help or are we content to "cool them out"? With growing shortages of manpower and with the growing press of claimants for service, it would indeed be a mockery to waste our human resources on busy work. The crying need is for rigorous studies evaluating outcome as we introduce new clinics, new services, new programs for community mental health (25).

A posteriori, it is easy to see the faults of earlier era and to overlook the devoted efforts of the legion of dedicated workers who applied what they believed to be true in a humane effort to ameliorate the distress of children. For that, all credit to them. Most of us can do no better than reflect the social perceptions of our times. The past quarter century, marked by the defeat of fascism and the upturning of economic indices, was one of social optimism in which the poor disappeared from American consciousness if not from the slums of our cities. The publication of Harrington's "The Other America" in 1962 (26) can be taken as a convenient marker for the cresting of a wave of public concern for the poor and the black which has given new impetus and more productive directions to research in child development.

Just as the moral treatment of the insane had flowered and died a century before we were to rediscover it as "millieu therapy" and "community mental Health", the antecedents of contemporary concerns with the effects of exogenous factors on cognitive development trace back at least that far (3). But with the explosive demographic changes in the post-war period - the

migration of the poor into center city areas, the flight of the affluent into suburbs and the decline in the urban tax base - the public school crisis has provided a new imperative for a long-standing issue.

Whether one examines I.Q. scores, achievement test results, years of schooling or almost any traditional index of academic success, one finds marked differences that co-vary with the social class of the child (27). Given the millions of children who are performing at marginal levels on the standard measures of academic achievement (28), it becomes an urgent matter to identify the source of this human wastage. Remember, we deal here not only with the immediate distress of the victimised child but with a predictable course of continuing failure as that child grows into an unemployable adult in a society ever more demanding of technical competence, at least as competence is measured by certificates and diplomas (29).

In a necessarily brief scan of recent research relevant to the public school scandal, I propose to touch upon the following issues: test bias, pre and para-natal factors, post-natal nutrition, family style, the school and, finally, the effects of racism.

Logically, the first question to be raised is whether the test score differences are "real" differences or merely artifacts of measurement. The answer depends upon what we suppose that the tests measure. If it is "innate ability", as the naive psychometrist may assert, then intelligence test score differences are simply irrelevant, since they register the interaction between biological potential and experience, with no way of distinguishing the one from the other (30). The pragmatist may assert nonetheless: what matters is the functional result whether it reflect environment, heredity, or both; are the functional differences real? Again, the answer will be

different for different measures. Pose the question this way: are there real deficits in ability to solve standard arithmetic problems or to read standard English paragraphs? The answer is an unequivocal: "yes". And this answer is a significant one; for, whatever other skills an adult may have, if he cannot use and read standard English, he will be seriously handicapped in negotiating the middle-class terrain where the material rewards of society are to be obtained. But there remains another question of major importance: is the child impaired in his ability to reason or do the language and the symbols in which the problem has been coded account for his performance failure?

It is by now abundantly clear that there <u>are</u> major differences in syntax as well as in vocabulary between middle and lower class languages (31) and between white and Negro dialects (32). I would caution you against the wide-spread assumption that what is different is defective. Lower caste language may be dysfunctional in a middle class world but it may convey every subtle nuance of meaning within the indigenous culture. However, the Negro child attending first grade may be facing the task of learning a new language as well as of learning to read, at one and the same time. If this analysis is correct, it may account in part for his performance breakdown; Mexican Indian children learn to read more readily if they are taught with primers transcribed in their own dialect rather than in the Spanish they are just beginning to master (33).

Moreover, a former colleague of mine, Professor Sonia Osler, has demonstrated that lower class children are able to profit from training (in learning to solve a concept problem) quite as well as middle class children with a mean I.Q. some fifteen points higher (34). Indeed, she calls our attention to how much <u>less</u> often there is any report of deficit when tasks

involving new learning are given to such children in contrast to tests reflecting cumulative accomplishment. In our own studies on children in Project Headstart, we have demonstrated statistically significant gains in such measures of "I.Q." as the Peabody Picture Vocabulary Test and the Goodenough-Harris after no more than a ten-week enrichment experience (35). I do not mean to maintain - and indeed I do not believe - that there are not significant impairments in the academic function of some of these children by the time of school-leaving age. But I would emphasize that (a) the differences are exaggerated by the linguistic code factor and (b) the ability to learn is preserved to an extent far greater than conventional test scores are able to register. Both of these propositions have important implications for compensatory education programs (36).

The second series of studies salient to this review concerns the pre- and para-natal factors that influence brain development. Professors Pasamanick and Knobloch, in a masterful series of investigations, have identified a "continuum of reproductive casualty" that extends at one end from spontaneous abortion and stillbirth through mental deficiency and epilepsy to learning disabilities and behavior disorders at the other (37). The underlying brain injuries are related to complications of pregnancy and parturition (toxemia, bleeding, infection, prematurity), complications which occur at significantly higher risk among the poor, the Black, the unmarried, the underaged and the overaged mother. These complications appear to result from an interaction between inadequate diet, poor prenatal care, poor housing and gross stress, each of which is associated with pregnancy outcome (38). Sequential follow-up studies have provided unequivocal evidence that the low birth-weight infant shows a high rate of neuropsychiatric dis-

order which results in serious impairment of academic performance (39). But the hazards that surround the perinatal period - unacceptable and needless as they are - should not be mistaken for the major source of academic failure. In a recent ten-year follow-up of a pregnancy cohort in Kauai, the authors concluded: "The overwhelming number of children with problems at age ten had relatively little or no perinatal stress, but they had grown up in homes low in socio-economic status, educational stimulation, and emotional support."(40).

The third related area of research centers on nutritional factors, both before and after birth. Although earlier studies of maternal diet during pregnancy had been inconclusive because birth-weight was used as the outcome measure, recent studies have indicated that low protein diet during pregnancy can lead to permanent stunting of subsequent adult stature even in animals not noticeably different at birth (41). A diet deficient in protein during the nursing period can induce permanent stunting in whole body and organ growth even when a free diet is made available to the young after weaning. Although the brain is proportionately less influenced than is total body weight, it does show significant growth retardation and the affected animals display poor performance in problem-solving situations (42). To turn to human data, the developmental quotient of children with kwashiorkior is markedly retarded and may not recover even after dietary repletion (43). In a study of children whose stature was taken as an index of earlier nutritional impairment, the authors found significant developmental delay in intersensory integration (44). More recently, Winick (45), employing DNA (desoxyribonucleic acid) content as a measure of cell number, has shown that there is a marked restriction in brain cell growth in malnourished infant animals. Careful DNA measurements on human infants adequately nourished

but dead of poisoning or infection has indicated that brain cell number continues to increase until five to six months of age. When these control values were compared with those from five children who died of severe malnutrition in the first year of life, there was a marked reduction in the number of brain cells in these infants, two of whom demonstrated a cell number less than 40% of normal! (45) Thus, it would appear that severe protein deficiency may wreak its havoc on intellectual development by interfering with cell multiplication during these crucial early months of development. The question that remains to be answered is whether this is a threshold phenomenon, appearing only when protein malnutrition exceeds some set value or whether it is graded and may appear in moderately malnourished children. Professor Monckeburg of Chile has recently reported an association between developmental level, physical growth retardation and level of protein intake as measured by careful dietary histories (46).

Here we confront a problem of world-wide significance, applying not only to the savage starvation that obtains in the underdeveloped countries, but as well to the less severely malnourished youngsters who populate Appalacia, the Black ghettoes of our cities, the Black belt of the South, the Indian and Eskimo reservation of North American and the Mexican American and Puerto Rican enclaves scattered through the United States (47). All of the facts may not be in, but those we do have demand a massive commitment by the wealthy nations of the world to ensure that no child starves. To await the final refinements in nutritional research is to condemn another generation of children to intellectual crippling - in Biafra, in Guatemala, in India, in pockets of poverty in our cities. Even as we study, we must act. We who, as students

of development, are aware of the grim toll of malnutrition, must take the lead in persuading our governments of the urgency of prompt intervention.

The fourth area of study moves us from the biosocial to the psychosocial sphere. The urban slum child grows up in a home bereft of books and often of newspapers, restricted in geographic experience to the few blocks surrounding his dwelling, denied the stimulating cultural vistas of museums and concerts, and limited to learning a non-standard language (48). His parents, like him, are likely to have been earlier victims of limited educational exposure and to have cognitive styles which differ significantly from those modal for the larger society. Professor Hess, now of Stanford University, has conducted a number of significant studies (49) employing the technique of direct laboratory observation of mothers and their four year old children during sessions in which the mother was asked to teach each of three simple previously mastered tasks to her child. Her strategies of control, her teaching styles, her language, and her affective behavior were carefully observed during this interaction. As expected, the middle class children performed at higher levels on a variety of measures than did the lower class children, all of them Negro in these studies. There were clear associations between maternal control strategies, teaching styles, language and affective behavior and the child's test performance. It should come to us as no revelation that the mother is the child's first teacher, but to say this is not to have identified the particular aspects of the mother/child relationship which are significant in the learning process and thereby to have indicated the critical points at which guided intervention can improve her skills. The work of Professor Hess has moved us a significant step in this direction.

Thus far, we have presented evidence that the child arrives at school already different in his mode of function from the middle class child for whom teaching styles have been designed. What of the effect of the school itself? School administrators are wont to displace the responsibility for his subsequent failure on to the "defects" of the child, whether they assert those defects to be congenital or acquired. Although it is somewhat more fashionable today to lay the blame on the home, the vehemence with which the defect theory is asserted implies the inherent nature and the incorrigibility of the defect. That the schools have not succeeded in helping the child who arrives at its doors different from the middle class norm is clear enough from the school achievement studies and drop-out rates described earlier. However, not only do they not succeed in reducing the achievement gap, but the test data demonstrate an ever-widening disparity (28). Can it be that the overcrowded, understaffed, undersupplied and discipline-oriented schools found in the urban slum may in fact have actively contributed to the child's failure? I cannot here review an extensive literature which suggests that this may indeed be the case (50), but will only call attention to several representative studies. In the Headstart research referred to earlier, Dr. Keith Conners was able to demonstrate that the amount of improvement in a class of children could be correlated with measures of the teachers cognitive, disciplinary and affective styles (35). Unhappily, the characteristics associated with better performance were those incompatible with the rigid authoritarian attitude suggested by a survey of urban school teachers carried out at the same time. Anecdotal reports and clinical experience suggest that many school teachers expect little and are not surprised when they get little from black children. And yet the importance of expectation has been demonstrated to be a major

influence on performance (51). In a California study, Professor Rosenthal and his associates administered a pre-test to first grade children, a number of whom were chosen at random to be identified to their school teachers as being likely to show great improvement during the school year. Not only did the teachers (in rating these children at the end of the year) describe them in more positive terms but the children themselves performed significantly better on achievement tests at the end of the year. And yet chance alone had dictated the selection of these "bloomers". The investigators did not, as ethical considerations dictated, single out other children as dull or likely to fall behind. But the data from this study together with a wealth of supporting material from other studies on social expectation (52) make it clear that depression of scores would have been recorded if such a companion study had been attempted. I suggest to you that this "study" has been being carried out for the last fifty years in public education because of our failure to imbue teachers with a concept of cognitive development that emphasizes its dependence upon the positive reinforcement of appropriate experience in the context of a warm and supporting human relationship. I suggest to you that it is not the children who fail but the schools that have failed and that it is we who have failed, because of our lack of involvement in the critical area of teacher education.

The final - and in many ways the most important - factor in this saga of human waste is racism: the attitudes and beliefs that deny full humanity to those who differ from us in color or culture. It is little comfort for Americans to recognize that this is a phenomenon found in Britain as well as the United States, in Nigeria as well as in South Africa, in India as well as in Poland, in Israel as well as in Egypt. The bio-social and psychosocial factors thus far discussed are intertwined with

racism; true, they occur even in its absence; witness the deprivation experienced by the poor regardless of ethnicity. But the intolerable burdens are multiplied by the housing ghettoes, the employment barriers, the lower pay scales and the barrage of psychological insult directed against those who are visibly different (53).

Given the greater biological hazards and the cultural differences that militate against attaining economic success, the further assault of a dominant culture that systematically degrades the characteristics that establish one's identity makes the task of growing up whole a particularly difficult one for the black child (54). If one is to attain a sense of potency: a conviction of one's manliness or womanliness, one must have a belief in the effectiveness of his own efforts as a determinant of personal attainment. But how can a conviction of personal competence be attained when skin color if one is black, automation if one is unskilled, illness if one is denied medical care, false imprisonment if one cannot obtain legal assistance, all issues beyond personal control, destroy the job, the savings, the dreams of the hardest working and the most dilligent?(55)

There is one antidote that may serve as a soul-saving measure, while the major struggle for human dignity is being fought. And that antidote, not without its own toxicity, is pride in race. We have begun to observe the growing strength in the United States of a movement that asserts that black is beautiful and that African culture is better than Western. United by common beliefs, black communities have begun to assert the rights of local control in policing, business interests, schooling, and urban planning. I count all of this a distinct psychological gain for the black and for the white community; whether it will succeed politically is still an open question.

When we turn to the public school crisis, we find the movement for local autonomy confronted by the vested interests in job and tenure of

the educational establishment, from the most underpaid teacher to the most prestigious school-board member. Mechanisms to enable local control and job security both to survive remain to be invented, but a significant shift in power is inevitable. In essence, the black community confronts us with these incontrovertible facts: integration has not moved forward in meaningful fashion in the twelve years since the Supreme Court decision; black children are not learning effectively in the schools run for them by the white establishment; the longer they wait for "goodwill" and "gradualism", the more their children will fall by the academic wayside. Could black run schools do worse? I do not believe so. Successes have been attained by "street academies" established by militant volunteers. There is, as I see it, good reason to support black power. It accepts the segregated housing patterns and school distributions as unavoidable phenomena of the near future. At least some of the spokesmen for black control anticipate a time when reunion and reintegration will be possible once the blacks have obtained political power as attested by the history of each of the immigrant groups to these shores. Will this prove to be true? It is the more likely to be true the greater the commitment of professionals to its success. It will provide us with an unique opportunity to study the interaction between self-concept and personal development if we make ourselves available to the new schools as contributors to their growth and investigators of the progress of their pupils. For they, no less than we, will want to learn where they succeed and where they fail and what will accelerate their development. Mind you, this will require that we be willing to learn even as we teach, that we abandon the arrogance of our own pretensions as standard bearers, that we become active participants and not merely "neutral" observers.

I believe that I have, by implication, answered the second of Dr. Cleghorn's injunctions: that I map out promises of research. For I am convinced that research in cognitive and personality development as resultants of the interaction between experience and maturation has been the major productive thrust of the past decade. If we, psychiatrists, are to contribute to the welfare of children, these are areas in which the most is to be learned and the most to be given.

If I may close on an historical note, I would recall to you a paper written thirty-five years ago by Joseph Brenneman, a distinguished pediatrician of his time, who gave his paper the ominous title: "The Menace of Psychiatry"(56). He decried the armchair speculations, the absence of empirical data and the confusing psychological theories that served only to upset parents and alienate pediatricians. In response, James Plant of the Essex County Juvenile Clinic, wrote "The Promise of Psychiatry" (57). His concluding paragraph included these statements:

> We are, as a people, going through great changes in the matter of human relationships. Whether you like it or not, the families which are your clientele are finding themselves face to face with new and profound social problems. These matters affect the conduct and health of the patients and serve to make every family part of our clientele, because every family is having to adjust itself to these changes. You cannot escape these problems and their implications to the child's health by deprecating them, nor can you solve or understand them by setting up a beautiful little experimental station where they do not exist. ... The promise of psychiatry is the promise that if the pediatrician will address himself to these problems he will face a vista of rare challenge. ... Personally, I am sorry if he is only afraid of that challenge.

And now let us jump three decades and I hope you will join me in echoing the words of Walter Orr Roberts, current president of the American Association for the Advancement of Science (58):

> Never before has the opportunity been so great. We have the knowledge and the means to achieve a living environment of unprecedented quality. And we can do this not only for one nation but for all who travel

with us on this planet. I have no illusions that it will be easy to achieve what we want from our civilization and our moment in history. It will clearly be a long and hazardous job, for scientist and citizen alike, to reach our goal for the human condition. But, as Thornton Wilder said, "every good and excellent thing stands moment by moment at the razor edge of danger, and must be fought for." Can we not wage the right kind of fight for the goal of the century twenty enlightenment?

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